Delta Dental of Virginia Clinical Policy # 705

Subject
Prophylactic Removal of Third Molar Teeth

Originating Department
Clinical Professional Services

Signature Authority
Dental Director

Type: [ ] New [ ] Replacement [x] Revision [ ] Clarification

Date: 11.15.2011
Revision Date: 01/16/2016

Preamble:
The Clinical Policy Bulletin is an expression of Delta Dental of Virginia’s (DDVA) determination regarding whether certain services or supplies are medically or dentally necessary. DDVA bases its conclusions on a review of currently available clinical literature. This includes, but is not limited to, clinical outcome studies published in the peer-reviewed medical and dental literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians and dentists practicing in pertinent clinical areas, and other applicable information. DDVA reserves the right to revise these policies as new clinical information is available and we welcome submission of further relevant information.

A group may define covered dental services under their dental plan, as well as those services that may be subject to dollar caps or other limits. The plan documents outline covered benefits, exclusions and limitations. DDVA advises dentists and subscribers to consult the plan documents to determine if there are exclusions or other benefit limitations applicable to the service request. The conclusion that a particular service is medically or dentally necessary does not constitute an indication or warranty that the service requested is a covered benefit payable by DDVA. Some plans exclude coverage for services that DDVA considers either medically or dentally necessary. When there is a discrepancy between DDVA’s clinical policy and the group’s plan documents, DDVA is to defer to the group’s plan documents as to whether the dental service is a covered benefit. In addition, if state or federal regulations mandate coverage then DDVA will adhere to the applicable regulatory requirement.

History:
Removal of third molar teeth at an early stage of development is a common recommendation by orthodontists for adolescents undergoing orthodontic treatment. While some of these extractions may be indicated in young adolescents, providers should be aware that prophylactic removal of third molars may be a non-covered benefit if the extractions do not meet the definition of dental necessity or the specific parameters of certain dental plans that benefit the removal of symptomatic or diseased teeth only.

Systematic reviews of the literature do not support prophylactic removal of unerupted third molar teeth that are not associated with a specific pathologic
process which would warrant removal(1,2,3,4,5).

For extraction benefits to be considered, third molars must meet the criteria for impacted teeth as defined by the ADA CDT manual(6). The ADA CDT manual defines an impaction as: “An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.” To qualify for removal as an impaction, a tooth must exhibit an impediment to a normal eruptive pattern such as horizontal orientation, significant mesial or distal angular inclination, or insufficient arch space. Of note is the fact that the position of unerupted third molar teeth can change through the middle of the third decade(7).

Documentation of the need for removal is required. Providers must submit diagnostic X-rays and a narrative/treatment rationale if applicable documenting the dental or medical necessity for removal.

Otherwise, if unerupted third molars do not meet the definition of a true impaction, to qualify for extraction the teeth must be associated with the presence of a localized pathologic process, such as infection/pericoronitis, multiple episodes of purulent exudate, inflammation, adjacent tooth resorption, bone loss at an adjacent tooth, pathologic cyst formation, traumatic occlusion from an opposing tooth, or pain associated with a localized, identifiable causative factor.

Removal of teeth for relief of non-specific symptoms, such as “headaches,” “jaw pain,” and discomfort associated with temporomandibular joint dysfunction (TMJ/TMD) do not meet criteria for treatment.

Additionally, removal of third molar teeth to “prevent crowding” or post-orthodontic “relapse” does not meet criteria for treatment. The role of third molar teeth relative to crowding may or may not be significant(2,3,8,9) and research has shown the etiology of tooth crowding to be nonspecific and multifactorial(10,11). The removal of third molar teeth has been shown to have no effect on late lower incisor crowding(12). No available research specifically isolates the presence of third molar teeth as a causative factor in crowding(13). The American Association of Oral and Maxillofacial Surgeons has issued the following statements: “Despite good intentions, we are not able to explain, predict, or prevent crowding, no matter what the cause. While it is likely that third molars play at least some role in the etiology of crowding, they are only one factor to consider in making a clinical decision about third molar management”(14).

Arch length discrepancies are often cited by practitioners as an indication for removal of unerupted third molar teeth. However, the age of the patient relative to continued growth of the maxilla and mandible must be taken into consideration. Research shows significant growth between the ages of eleven and seventeen(15), with mandibular growth approximately twice that of the maxilla(16). Facial growth is approximately 98% completed by age 17-18 in adolescent males and by age 15 in adolescent females(17). Facial growth may
continue past these ages, and in particular, late mandibular growth is often observed in post-pubertal teens(18).

In 2011, the American Association of Oral and Maxillofacial surgeons published a position statement regarding extraction of third molar teeth relative to the fact that some insurance carriers do not allow benefits for extraction of impactions which are “disease free” and “asymptomatic”. The paper points out that impacted teeth which appear to be disease free and asymptomatic may in fact be involved with undiagnosed pathologic processes such as occult cyst formation and asymptomatic periodontal bone loss. In general, AAOMS advocates early extraction of disease free/asymptomatic impactions based on research literature indicating the increased incidence and development of pathologic states and increased morbidity with late stage extractions. The AAMOS paper specifically supports extraction of third molars “even if the teeth are asymptomatic, if there is the presence or reasonable potential that pathology may occur caused by or related to the third molar teeth”. DDVA likewise supports extraction of third molars if these circumstances can be demonstrated and documented. However, for many patients, third molars may erupt into the arch without consequence and serve as useful teeth. Early extraction precludes the use of third molars as functional teeth and as possible abutments for tooth replacement devices. DDVA does not support the prophylactic extraction of impacted teeth in adolescents or during the developmental stage of a tooth unless there is the presence of a disease state, a pathologic process, or a specific impediment to a normal eruptive pattern.

**Policy/Therapy Guidelines:**

DDVA recommends that, prior to removal of bone/soft tissue impacted, unerupted teeth not associated with a documented localized pathologic process, providers submit a predetermination of benefits. Providers may refer to treatment guidelines in Clinical Policy #700 on tooth extraction.

**ADA/CDT Codes (19):**

D7220, D7230, D7240, D7241

**References:**


